

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 W HOMER ST MICHIGAN CITY, IN 46360</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>HFAP Surveyor: 33212 Facility Number: 005015</p> <p>Type of Survey: State Licensure Off Site HFAP Accreditation Survey</p> <p>Date of HFAP On Site Survey - Hospital full survey 1/28-31/2014</p> <p>Date of ISDH off site review - 12/09/2014</p> <p>Reviewer/Surveyor Nancy Otten RN, PHNS</p> <p>Based on review of the January 28-31/2014 HFAP Accreditation Survey Report, it has been determined that Franciscan St. Anthony Health meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE